UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ORENCIA(abatacept)

Patient name:_____Medicaid or SS#_____

Physician Name:_____Contact person:_____

Phone#:_____Ext. and opt:_____Fax#_____

Physician's NPI:_____

Patient's current wt. _____Am't per dose_____# of tx in 6 mos_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTE OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Patient is 18 years old or older
- Covered for moderate to severe rheumatoid arthritis
- Must have inadequate response to one or more DMARD's such as MTX ***OR***
  have inadequate response to one or more TNF such as anakinra, enteracept or infliximab
- Patient is not on TNF medication
- 6 or more swollen joints **(WRITE SPECIFIC NUMBER IN NOTES OR LETTER)**
- 9 or more tender joints (**WRITE SPECIFIC NUMBER IN NOTES OR LETTER)**
- Patient is absent of active bacterial or viral infection, malignancy, or immunosuppressive condition
- There has been a rheumatology consult within the last 60 days

INFORMATION:

To be administered in clinic setting only. Patient's with HMO's (except IHC) will have to make arrangements with their HMO coverage. Provider will bill with J code J0129 and a PA number.

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

An updated letter or progress note needs to be sent in showing improvement or maintenance as the result of using Orencia.

7/19/6